

		FOR BHF USE					

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2012
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2012)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: <u>0050609</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																							
Facility Name: <u>Lebanon Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/2012</u> to <u>12/31/2012</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																							
Address: <u>1201 North Alton</u> <u>Lebanon</u> <u>62254</u>																									
Number City Zip Code																									
County: <u>St. Clair</u>																									
Telephone Number: <u>(618) 537-4401</u> Fax # <u>(618) 537-4447</u>																									
HFS ID Number: _____		<table><tr><td rowspan="2">Officer or Administrator of Provider</td><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr><tr><td rowspan="4">Paid Preparer</td><td>(Type or Print Name) <u>Mark B. Petersen</u></td></tr><tr><td>(Title) <u>Chief Executive Officer</u></td></tr><tr><td>(Signed) _____</td></tr><tr><td>(Date) _____</td></tr></table>		Officer or Administrator of Provider	(Signed) _____	(Date) _____	Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>	(Title) <u>Chief Executive Officer</u>	(Signed) _____	(Date) _____														
Officer or Administrator of Provider	(Signed) _____																								
	(Date) _____																								
Paid Preparer	(Type or Print Name) <u>Mark B. Petersen</u>																								
	(Title) <u>Chief Executive Officer</u>																								
	(Signed) _____																								
	(Date) _____																								
Date of Initial License for Current Owners: <u>7/31/2007</u>																									
Type of Ownership:																									
<table><tr><td>☐ VOLUNTARY,NON-PROFIT</td><td>☒ PROPRIETARY</td><td>☐ GOVERNMENTAL</td></tr><tr><td>☐ Charitable Corp.</td><td>☐ Individual</td><td>☐ State</td></tr><tr><td>☐ Trust</td><td>☐ Partnership</td><td>☐ County</td></tr><tr><td>IRS Exemption Code _____</td><td>☐ Corporation</td><td>☐ Other _____</td></tr><tr><td></td><td>☐ "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td>☒ Limited Liability Co.</td><td>_____</td></tr><tr><td></td><td>☐ Trust</td><td>_____</td></tr><tr><td></td><td>☐ Other _____</td><td>_____</td></tr></table>		☐ VOLUNTARY,NON-PROFIT	☒ PROPRIETARY	☐ GOVERNMENTAL	☐ Charitable Corp.	☐ Individual	☐ State	☐ Trust	☐ Partnership	☐ County	IRS Exemption Code _____	☐ Corporation	☐ Other _____		☐ "Sub-S" Corp.	_____		☒ Limited Liability Co.	_____		☐ Trust	_____		☐ Other _____	_____
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	☐ Trust	_____																							
	☐ Other _____	_____																							
In the event there are further questions about this report, please contact:		MAIL TO: BUREAU OF HEALTH FINANCE ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																							
Name: <u>Mike Kocher</u> Telephone Number: <u>(309)689-5850</u>																									
Email Address: _____																									

Facility Name & ID Number Lebanon Care Center# 0050609 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32,850</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,979</u>	<u>3,187</u>	<u>1,374</u>	<u>15,540</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>10,979</u>	<u>3,187</u>	<u>1,374</u>	<u>15,540</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 47.31%

D. How many bed-hold days during this year were paid by the Department?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☒

NO

☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 7/31/2007

J. Was the facility purchased or leased after January 1, 1978?

YES

☒Date 7/31/2007

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

90

and days of care provided

1,012Medicare Intermediary National Government Services

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒NO ☐Tax Year: 12/31/12Fiscal Year: 12/31/12

* All facilities other than governmental must report on the accrual basis.

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
		1	2	3	4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	126,810	14,847		141,657		141,657	2,829	144,486			1
2	Food Purchase		98,833		98,833		98,833	(3,354)	95,479			2
3	Housekeeping	116,122	24,167		140,289		140,289	22	140,311			3
4	Laundry	6,889	8,930		15,819		15,819	4	15,823			4
5	Heat and Other Utilities			74,672	74,672		74,672	223	74,895			5
6	Maintenance	26,803	13,884	24,975	65,662		65,662	1,750	67,412			6
7	Other (specify):* Home Off. Ben. All.							377	377			7
8	TOTAL General Services	276,624	160,661	99,647	536,932		536,932	1,851	538,783			8
	B. Health Care and Programs											
9	Medical Director			13,800	13,800		13,800		13,800			9
10	Nursing and Medical Records	805,315	49,544	3,939	858,798		858,798	27	858,825			10
10a	Therapy			224,451	224,451		224,451		224,451			10a
11	Activities	25,656	471	279	26,406		26,406	(3,151)	23,255			11
12	Social Services	35,070			35,070		35,070		35,070			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* Home Off. Ben. All.											15
16	TOTAL Health Care and Programs	866,041	50,015	242,469	1,158,525		1,158,525	(3,124)	1,155,401			16
	C. General Administration											
17	Administrative			268,600	268,600		268,600	(216,453)	52,147			17
18	Directors Fees											18
19	Professional Services			11,335	11,335		11,335	17,929	29,264			19
20	Dues, Fees, Subscriptions & Promotions			1,239	1,239		1,239	332	1,571			20
21	Clerical & General Office Expenses	26,224	4,275	11,482	41,981		41,981	32,622	74,603			21
22	Employee Benefits & Payroll Taxes			171,775	171,775		171,775	515	172,290			22
23	Inservice Training & Education			450	450		450	53	503			23
24	Travel and Seminar							5	5			24
25	Other Admin. Staff Transportation			7,854	7,854		7,854	5,416	13,270			25
26	Insurance-Prop.Liab.Malpractice			27,954	27,954		27,954	605	28,559			26
27	Other (specify):* Home Off. Ben. All.							7,554	7,554			27
28	TOTAL General Administration	26,224	4,275	500,689	531,188		531,188	(151,422)	379,766			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,168,889	214,951	842,805	2,226,645		2,226,645	(152,695)	2,073,950			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			111,830	111,830		111,830	(10,052)	101,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,390	134,390		134,390	26,045	160,435			32
33	Real Estate Taxes			64,093	64,093		64,093	400	64,493			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			15,378	15,378		15,378	490	15,868			35
36	Other (specify):*											36
37	TOTAL Ownership			325,691	325,691		325,691	16,883	342,574			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		46,637		46,637		46,637		46,637			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			205,075	205,075		205,075		205,075			42
43	Other (specify):* Non-allowable Costs		96	171,241	171,337		171,337	(171,337)				43
44	TOTAL Special Cost Centers		46,733	376,316	423,049		423,049	(171,337)	251,712			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,168,889	261,684	1,544,812	2,975,385		2,975,385	(307,149)	2,668,236			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,449)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,080)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,895)	30		9
10	Interest and Other Investment Income	(1,458)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(232)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(21,158)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(140,562)	43		24
25	Fund Raising, Advertising and Promotional	(1,426)	43		25
	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	(6,662)	Various		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (192,922)		\$	30

BHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(114,227)	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (114,227)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (307,149)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Lebanon Care Center

Report Period Beginning: 1/1/2012
Ending: 12/31/2012

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Labs-Part A	\$ (2,089)	43	1
2	X-Rays-Part A	(755)	43	2
3	Offset Miscellaneous Activity Supplies	(370)	11	3
4	Offset Transportation Revenue	(2,781)	11	4
5	Offset Miscellaneous Office Supplies Revenue	(632)	21	5
6	Resident Flowers	(35)	43	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(6,662)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lebanon Care Center

0050609

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	2,829	0	0	0	0	0	0	0	0	0	2,829	1
2	Food Purchase	(3,449)	95	0	0	0	0	0	0	0	0	0	(3,354)	2
3	Housekeeping	0	22	0	0	0	0	0	0	0	0	0	22	3
4	Laundry	0	4	0	0	0	0	0	0	0	0	0	4	4
5	Heat and Other Utilities	0	223	0	0	0	0	0	0	0	0	0	223	5
6	Maintenance	0	1,569	0	181	0	0	0	0	0	0	0	1,750	6
7	Other (specify):*	0	377	0	0	0	0	0	0	0	0	0	377	7
8	TOTAL General Services	(3,449)	5,119	0	181	0	0	0	0	0	0	0	1,851	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	27	0	0	0	0	0	0	0	0	0	27	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,151)	0	0	0	0	0	0	0	0	0	0	(3,151)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(3,151)	27	0	0	0	0	0	0	0	0	0	(3,124)	16
	C. General Administration													
17	Administrative	0	(216,453)	0	0	0	0	0	0	0	0	0	(216,453)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	15,281	0	0	0	0	0	0	0	0	0	15,281	19
20	Fees, Subscriptions & Promotions	0	0	218	2,648	0	0	0	0	0	0	0	2,866	20
21	Clerical & General Office Expenses	(632)	0	32,022	114	0	0	0	0	0	0	0	31,504	21
22	Employee Benefits & Payroll Taxes	0	0	0	1,232	0	0	0	0	0	0	0	1,232	22
23	Inservice Training & Education	0	0	53	515	0	0	0	0	0	0	0	568	23
24	Travel and Seminar	0	0	5	0	0	0	0	0	0	0	0	5	24
25	Other Admin. Staff Transportation	0	0	3,669	1,747	0	0	0	0	0	0	0	5,416	25
26	Insurance-Prop.Liab.Malpractice	0	0	605	0	0	0	0	0	0	0	0	605	26
27	Other (specify):*	0	0	7,554	0	0	0	0	0	0	0	0	7,554	27
28	TOTAL General Administration	(632)	(201,172)	44,126	6,256	0	0	0	0	0	0	0	(151,422)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(7,232)	(196,026)	44,126	6,437	0	0	0	0	0	0	0	(152,695)	29

Summary B

12/31/2012

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒	X	YES	☐	NO
--	----------	------------	--------------------------	-----------

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	<u>Dietary</u>	\$	<u>Petersen Health Care, Inc.</u>	100.00%	\$ 2,829	\$ 2,829	1
2	V	2	<u>Food</u>		<u>Petersen Health Care, Inc.</u>	100.00%	95	95	2
3	V	3	<u>Housekeeping</u>		<u>Petersen Health Care, Inc.</u>	100.00%	22	22	3
4	V	4	<u>Laundry</u>		<u>Petersen Health Care, Inc.</u>	100.00%	4	4	4
5	V	5	<u>Utilities</u>		<u>Petersen Health Care, Inc.</u>	100.00%	223	223	5
6	V	6	<u>Maintenance</u>		<u>Petersen Health Care, Inc.</u>	100.00%	1,569	1,569	6
7	V	7	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	377	377	7
8	V	10	<u>Nursing and Medical Records</u>		<u>Petersen Health Care, Inc.</u>	100.00%	27	27	8
9	V	10A	<u>Therapy</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		9
10	V	15	<u>Mgmt. Allocation of Benefits</u>		<u>Petersen Health Care, Inc.</u>	100.00%	0		10
11	V	17	<u>Administrative</u>	268,600	<u>Petersen Health Care, Inc.</u>	100.00%	52,147	(216,453)	11
12	V	19	<u>Professional Services</u>		<u>Petersen Health Care, Inc.</u>	100.00%	15,281	15,281	12
13	V								13
14	Total			\$ 268,600			\$ 72,574	\$ * (196,026)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	20	Dues, Fees, Subs & Promotions	\$	Petersen Health Care, Inc.	100.00%	\$ 218	\$ 218	15
16	V	21	Clerical and General Office		Petersen Health Care, Inc.	100.00%	32,022	32,022	16
17	V	23	Inservice Training & Education		Petersen Health Care, Inc.	100.00%	53	53	17
18	V	24	Travel and Seminar		Petersen Health Care, Inc.	100.00%	5	5	18
19	V	25	Other Admin. Staff Transport.		Petersen Health Care, Inc.	100.00%	3,669	3,669	19
20	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Care, Inc.	100.00%	605	605	20
21	V	27	Mgmt. Allocation of Benefits		Petersen Health Care, Inc.	100.00%	7,554	7,554	21
22	V	30	Depreciation		Petersen Health Care, Inc.	100.00%	2,718	2,718	22
23	V	32	Interest		Petersen Health Care, Inc.	100.00%	5,404	5,404	23
24	V	33	Real Estate Taxes		Petersen Health Care, Inc.	100.00%	400	400	24
25	V	34	Rent-Facility and Grounds		Petersen Health Care, Inc.	100.00%	0		25
26	V	35	Rent-Equipment & Vehicles		Petersen Health Care, Inc.	100.00%	398	398	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 53,046	\$ * 53,046	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number	Lebanon Care Center	#	0050609	Report Period Beginning:	1/1/2012	Ending:	12/31/2012
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VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	\$	Petersen Health Network, LLC	100.00%	\$ 0	\$	15
16	V	2	Food		Petersen Health Network, LLC	100.00%	0		16
17	V	3	Housekeeping		Petersen Health Network, LLC	100.00%	0		17
18	V	4	Laundry		Petersen Health Network, LLC	100.00%	0		18
19	V	5	Utilities		Petersen Health Network, LLC	100.00%	0		19
20	V	6	Maintenance		Petersen Health Network, LLC	100.00%	181	181	20
21	V	7	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		21
22	V	10	Nursing and Medical Records		Petersen Health Network, LLC	100.00%	0		22
23	V	12	Social Services		Petersen Health Network, LLC	100.00%	0		23
24	V	17	Administrative		Petersen Health Network, LLC	100.00%	0		24
25	V	19	Professional Services		Petersen Health Network, LLC	100.00%	0		25
26	V	20	Dues, Fees, Subs & Promotions		Petersen Health Network, LLC	100.00%	2,648	2,648	26
27	V	21	Clerical and General Office		Petersen Health Network, LLC	100.00%	114	114	27
28	V	22	Employee Benefits & Payroll		Petersen Health Network, LLC	100.00%	1,232	1,232	28
29	V	23	Inservice Training & Education		Petersen Health Network, LLC	100.00%	515	515	29
30	V	24	Travel and Seminar		Petersen Health Network, LLC	100.00%	0		30
31	V	25	Other Admin. Staff Transport.		Petersen Health Network, LLC	100.00%	1,747	1,747	31
32	V	26	Insurance-Prop./Liab./Malprac.		Petersen Health Network, LLC	100.00%	0		32
33	V	27	Mgmt. Allocation of Benefits		Petersen Health Network, LLC	100.00%	0		33
34	V	30	Depreciation		Petersen Health Network, LLC	100.00%	125	125	34
35	V	32	Interest		Petersen Health Network, LLC	100.00%	22,099	22,099	35
36	V	33	Real Estate Taxes		Petersen Health Network, LLC	100.00%	0		36
37	V	34	Rent-Facility and Grounds		Petersen Health Network, LLC	100.00%	0		37
38	V	35	Rent-Equipment & Vehicles		Petersen Health Network, LLC	100.00%	92	92	38
39	Total			\$			\$ 28,753	\$ * 28,753	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number

Lebanon Care Center

0050609

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Aledo Health Care Center	Aledo	Petersen Companies, I	Peoria	Mgmt/Bookkeeping	1
2			Arcola Health Care Center	Arcola	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	2
3			Aspen Rehab & Health Care	Silvis	Petersen Health Care,	Peoria	Mgmt/Bookkeeping	3
4			Batavia Rehab & Health Care Center	Batavia	Petersen Health Enter	Peoria	Mgmt/Bookkeeping	4
5			Bement Health Care Center	Bement	Petersen Health Opera	Peoria	Mgmt/Bookkeeping	5
6			Benton Rehab & Health Care Center	Benton	Petersen Health Syste	Peoria	Mgmt/Bookkeeping	6
7			Bloomington Rehab & Health Care Center	Bloomington	Petersen Hotels LLC	Peoria	Hospitality	7
8			Casey Health Care Center	Casey	Petersen Restaurants,	Peoria	Restaurant	8
9			Charleston Rehab & Health Care Center	Charleston	Petersen Health Care I	Peoria	Mgmt/Bookkeeping	9
10			Cisne Rehab & Health Care Center	Cisne	Petersen Health Care	Peoria	Mgmt/Bookkeeping	10
11			Countryview Care Center of Macomb	Macomb	Petersen Health Care	Peoria	Mgmt/Bookkeeping	11
12			Countryview Terrace	Louisville	Petersen Health Care	Sullivan	Lessor	12
13			Cumberland Rehab & Health Care Center	Greenup	Petersen Health Care	Peoria	Mgmt/Bookkeeping	13
14			Decatur Rehab & Health Care Center	Decatur	Petersen Health Care I	Peoria	Lessor	14
15			Eastside Health & Rehabilitation Center	Pittsfield	Petersen Osage Beach,	Osage Beach, MO	Lessor	15
16			Eastview Terrace	Sullivan	Petersen West Frankfo	West Frankfort	Lessor	16
17			El Paso Health Care Center	El Paso	Midwest Health Care,	Peoria	Mgmt/Bookkeeping	17
18			Enfield Rehab & Health Care Center	Enfield	Poplar Bluff Health C	Poplar Bluff, MO	Lessor	18
19			Farmer City Rehab & Health Care Center	Farmer City	Petersen Roseville, LL	Roseville	Lessor	19
20			Flanagan Rehab & Health Care Center	Flanagan				20
21			Flora Gardens Care Center	Flora				21
22			Flora Health Care Center	Flora				22
23			Fondulac Rehab & Health Care Center	East Peoria				23
24			Havana Health Care Center	Havana				24
25			Illini Heritage Rehab & Health Care	Champaign				25
26			Jonesboro Rehab & Health Care Center	Jonesboro				26
27			Kewanee Care Home	Kewanee				27
28			LaHarpe Davier Health Care Center	LaHarpe				28
29			Lebanon Care Center	Lebanon				29
30			Marigold Rehab & Health Care Center	Galesburg				30

Facility Name & ID Number

Lebanon Care Center

0050609

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Mason Point	Sullivan				1
2			McLeansboro Rehab & Health Care Center	McLeansboro				2
3			Mt. Vernon Health Care Center	Mt. Vernon				3
4			Newman Rehab & Health Care Center	Newman				4
5			Nokomis Rehab & Health Care Center	Nokomis				5
6			North Aurora Care Center	North Aurora				6
7			Orchard View Rehab & Health Care Center	Princeton				7
8			Palm Terrace of Mattoon	Mattoon				8
9			Piper City Rehab & Living Center	Piper City				9
10			Pleasant View Rehab & Health Care Center	Morrison				10
11			Polo Rehabilitation & Health Care Center	Polo				11
12			Prairie City Rehab & Health Care Center	Prairie City				12
13			Robings Manor Nursing Home	Brighton				13
14			Rochelle Gardens	Rochelle				14
15			Rochelle Rehab & Health Care Center	Rochelle				15
16			Rock Falls Rehab & Health Care Center	Rock Falls				16
17			Arrow Wood Independent Living	Rock Falls				17
18			Roseville Rehab and Health Care Center	Roseville				18
19			Rosiclare Rehab & Health Care Center	Rosiclare				19
20			Royal Oaks Care Center	Kewanee				20
21			Sandwich Rehab & Health Care Center	Sandwich				21
22			Iron Wood Independent Living	Sandwich				22
23			Shawnee Rose Care Center	Harrisburg				23
24			Shelbyville Rehab & Health Care Center	Shelbyville				24
25			South Elgin Rehab & Health Care Center	South Elgin				25
26			Sugar Creek Care Center	Watseka				26
27			Sullivan Health Care Center	Sullivan				27
28			Sunset Manor Nursing Home	Canton				28
29			Swansea Rehab & Health Care	Swansea				29
30			Timbercreek Rehab & Health Center	Pekin				30

Facility Name & ID Number

Lebanon Care Center

0050609

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Toulon Health Care Center	Toulon				1
2			Tuscola Health Care Center	Tuscola				2
3			Twin Lakes Rehab & Health Care Center	Paris				3
4			Vandalia Rehab & Health Care Center	Vandalia				4
5			Watseka Health Care Center	Watseka				5
6			Westside Rehab & Care Center	West Frankfort				6
7			Whispering Oaks	Rosiclare				7
8			White Oak Rehab & Health Care Center	Mt. Vernon				8
9			Willow Rose Rehab & Health Care Center	Jerseyville				9
10			Sheldon Health Care Center	Sheldon				10
11			Tuscola Health Care Center	Tuscola				11
12			Effingham Health Care Center	Effingham				12
13			Collinsville Health Care Center	Collinsville				13
14			Ozark Rehab & Health Care Center	Osage Beach, MO				14
15			South Shore Health Care, LLC	Gary, IN				15
16			Cedargate Skilled Nursing Facility	Poplar Bluff, MO				16
17			Tarkio Rehab & Health Care Center	Tarkio, MO				17
18			Shangri-la Rehab & Living Center	Blue Springs, MO				18
19			Prairie Rose Care Center	Pana				19
20			Illini Heritage Rehab & Health Center	Champaign				20
21			Courtyard Estates of Kewanee	Kewanee				21
22			Courtyard Estates of Bradford	Bradford				22
23			Courtyard Estates of Galva	Galva				23
24			Courtyard Estates of Walcott	Walcott				24
25			Courtyard Village of Kewanee	Kewanee				25
26			Lakewood Village	Charleston				26
27			Courtyard Estates of Monmouth	Monmouth				27
28			Riverview Estates	Havana				28
29			Simple Blessings	Casey				29
30			Courtyard Estates of Bushnell	Bushnell				30

VII. RELATED PARTIES

A. (Continued) Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1			Courtyard Estates of Canton	Canton				1
2			Legacy Estates of Monmouth	Monmouth				2
3			Courtyard Estates of Sullivan	Sullivan				3
4			Courtyard Estates of Peoria	Peoria				4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Lebanon Care Center # 0050609 Report Period Beginning: 1/1/2012 Ending: 12/31/2012

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1											1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lebanon Care Center# 0050609

Report Period Beginning:

1/1/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Care, Inc.

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	1,569,393	74	\$ 285,707	\$ 284,214	15,540	\$ 2,829	1
2	2	Food	Resident Days	1,569,393	74	9,632	0	15,540	95	2
3	3	Housekeeping	Resident Days	1,569,393	74	2,201	0	15,540	22	3
4	4	Laundry	Resident Days	1,569,393	74	397	0	15,540	4	4
5	5	Utilities	Resident Days	1,569,393	74	22,546	0	15,540	223	5
6	6	Maintenance	Resident Days	1,569,393	74	158,485	73,431	15,540	1,569	6
7	7	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	38,057	0	15,540	377	7
8	10	Nursing and Medical Records	Resident Days	1,569,393	74	2,750	0	15,540	27	8
9	10A	Therapy	Resident Days	1,569,393	74	0	0	15,540	0	9
10	15	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	0	0	15,540	0	10
11	17	Administrative	Resident Days	1,569,393	74	4,353,655	4,353,655	15,540	52,147	11
12	19	Professional Services	Resident Days	1,569,393	74	1,543,275	0	15,540	15,281	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	1,569,393	74	21,988	0	15,540	218	13
14	21	Clerical and General Office	Resident Days	1,569,393	74	3,233,970	2,816,787	15,540	32,022	14
15	23	Inservice Training & Education	Resident Days	1,569,393	74	5,397	0	15,540	53	15
16	24	Travel and Seminar	Resident Days	1,569,393	74	535	0	15,540	5	16
17	25	Other Admin. Staff Transport.	Resident Days	1,569,393	74	370,568	0	15,540	3,669	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	1,569,393	74	61,077	0	15,540	605	18
19	27	Mgmt. Allocation of Benefits	Resident Days	1,569,393	74	762,912	0	15,540	7,554	19
20	30	Depreciation	Resident Days	1,569,393	74	274,514	0	15,540	2,718	20
21	32	Interest	Resident Days	1,569,393	74	545,764	0	15,540	5,404	21
22	33	Real Estate Taxes	Resident Days	1,569,393	74	40,424	0	15,540	400	22
23	34	Rent-Facility and Grounds	Resident Days	1,569,393	74	0	0	15,540	0	23
24	35	Rent-Equipment & Vehicles	Resident Days	1,569,393	74	40,223	0	15,540	398	24
25	TOTALS					\$ 11,774,077	\$ 7,528,087		\$ 125,620	25

Facility Name & ID Number Lebanon Care Center# 0050609

Report Period Beginning:

1/1/2012Ending: 2/31/2012

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization

Petersen Health Network, LLC

Street Address

830 W. Trailcreek Drive

City / State / Zip Code

Peoria, IL 61614

Phone Number

(309) 691-8113

Fax Number

(309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Resident Days	207,636	12	\$	\$	15,540	\$	1
2	2	Food	Resident Days	207,636	12			15,540		2
3	3	Housekeeping	Resident Days	207,636	12			15,540		3
4	4	Laundry	Resident Days	207,636	12			15,540		4
5	5	Utilities	Resident Days	207,636	12			15,540		5
6	6	Maintenance	Resident Days	207,636	12	2,422		15,540	181	6
7	7	Mgmt. Allocation of Benefits	Resident Days	207,636	12			15,540		7
8	10	Nursing and Medical Records	Resident Days	207,636	12			15,540		8
9	10A	Therapy	Resident Days	207,636	12			15,540		9
10	15	Mgmt. Allocation of Benefits	Resident Days	207,636	12			15,540		10
11	17	Administrative	Resident Days	207,636	12			15,540		11
12	19	Professional Services	Resident Days	207,636	12	35,385		15,540	2,648	12
13	20	Dues, Fees, Subs & Promotions	Resident Days	207,636	12	1,525		15,540	114	13
14	21	Clerical and General Office	Resident Days	207,636	12	16,458		15,540	1,232	14
15	22	Employee Benefits & Payroll	Resident Days	207,636	12	6,884		15,540	515	15
16	24	Travel and Seminar	Resident Days	207,636	12			15,540		16
17	25	Other Admin. Staff Transport.	Resident Days	207,636	12	23,340		15,540	1,747	17
18	26	Insurance-Prop./Liab./Malprac.	Resident Days	207,636	12			15,540		18
19	27	Mgmt. Allocation of Benefits	Resident Days	207,636	12			15,540		19
20	30	Depreciation	Resident Days	207,636	12	1,668		15,540	125	20
21	32	Interest	Resident Days	207,636	12	295,279		15,540	22,099	21
22	33	Real Estate Taxes	Resident Days	207,636	12			15,540		22
23	34	Rent-Facility and Grounds	Resident Days	207,636	12			15,540		23
24	35	Rent-Equipment & Vehicles	Resident Days	207,636	12	1,227		15,540	92	24
25	TOTALS					\$ 384,188	\$		\$ 28,753	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	The Private Bank		X	Mortgage	Varies	10/31/09	1,917,567	\$ 1,814,674	11/1/14	Varies	\$ 134,390	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$ 1,917,567	\$ 1,814,674			\$ 134,390	9	
	B. Non-Facility Related*												
10												10	
11								Interest Income Offset			(1,458)	11	
12								Home Office Allocation-PHC			5,404	12	
13								Home Office Allocation-PHN			22,099	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 26,045	14	
15	TOTALS (line 9+line14)						\$ 1,917,567	\$ 1,814,674			\$ 160,435	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2011 report.			\$	59,760	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		2011	\$	61,009	2
3. Under or (over) accrual (line 2 minus line 1).			\$	1,249	3
4. Real Estate Tax accrual used for 2012 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	62,844	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				400	
TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	64,493	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		2007	53,815	8	
		2008	54,797	9	
		2009	57,552	10	
		2010	58,003	11	
		2011	61,009	12	
Accrual based on prior year tax bill.					

FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2011 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

2011 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME	<u>Lebanon Care Center</u>	COUNTY	<u>St. Clair</u>
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FACILITY IDPH LICENSE NUMBER 0050609

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309)691-8113 FAX #: (309) 691-8622

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2011 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2011.

(A)		(B)	(C)	(D)
<u>Tax Index Number</u>		<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	05-18.0-300-018	Long-Term Care Facility	\$ 1,735.14	\$ 1,735.14
2.	05-18.0-309-012	Long-Term Care Facility	\$ 59,273.98	\$ 59,273.98
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
TOTALS			\$ 61,009.12	\$ 61,009.12

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2011 tax bills which were listed in Section A to this statement. Be sure to use the 2011 tax bill which is normally paid during 2012.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:	31,919	B. General Construction Type:	Exterior	Brick	Frame	Concrete & Steel	Number of Stories	1
------------------------	---------------	--------------------------------------	-----------------	--------------	--------------	-----------------------------	--------------------------	----------

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: _____ **2. Number of Years Over Which it is Being Amortized:** _____

3. Current Period Amortization: _____ **4. Dates Incurred:** _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	17,240	2007	\$ 100,000	1
2					2
3	TOTALS	17,240		\$ 100,000	3

Facility Name & ID Number Lebanon Care Center

0050609

Report Period Beginning:

1/1/2012

Ending:

12/31/2012

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	90		2007	1986	\$ 1,425,000	\$	25	\$ 57,000	\$ 57,000	\$ 313,500	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Original Land Improvements			2007	15,000		15	1,000	1,000	5,500	9	
10	Lobby Carpet			2007	2,050		7	293	293	1,612	10	
11	Facility Sign			2007	640		7	91	91	501	11	
12	Wood Blinds			2007	1,158		7	165	165	908	12	
13	Cable Equipment Installation			2009	7,264		7	1,038	1,038	2,760	13	
14	Generator Repair			2010	3,400		7	486	486	1,215	14	
15	Fabrication work			2010	107,400		20	5,370	5,370	13,425	15	
16	Fire Sprinkler Repair			2011	9,853		7	1,408	1,408	2,112	16	
17	Water Heater			2011	3,373		7	482	482	723	17	
18	Heat Exchanger			2011	3,700		15	246	246	369	18	
19	Roof Replacement on West Wing			2011	26,346		25	1,054	1,054	1,581	19	
20	Roof Repairs			2012	2,902		7	207	207	207	20	
21	Smoke Detector			2012	6,570		15	219	219	219	21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30	Land Improvements Booked					1,000			(1,000)		30	
31	Building Booked					57,000			(57,000)		31	
32	Building Improvement Booked					11,123			(11,123)		32	
33											33	
34	2012-Home Office Allocation-Land Improvements				678			43	43		34	
35	2012-Home Office Allocation-Building Improvements				7,268			174	174		35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,622,602	\$ 69,123		\$ 69,276	\$ 153	\$ 344,632	70

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 297,676	\$ 42,525	\$ 29,767	\$ (12,758)	5-10 yrs.	\$ 161,126	71
72	Current Year Purchases	2,187	182	109	(73)	10 yrs.	109	72
73	Fully Depreciated Assets							73
74	Home Office Allocation			2,626	2,626			74
75	TOTALS	\$ 299,863	\$ 42,707	\$ 32,502	\$ (10,205)		\$ 161,235	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77	N/A									77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,022,465	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 111,830	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 101,778	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (10,052)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 505,867	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
16. Rental Amount for movable equipment: \$ 9,406 Description: See Attached Schedule 14A
(Attach a schedule detailing the breakdown of movable equipment)
- ☐ YES☐ NO

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2009 Ford E150	\$ 538.52	\$ 6,462	17
18					18
19					19
20					20
21	TOTAL		\$ 538.52	\$ 6,462	21

10. Effective dates of current rental agreement:
Beginning
Ending
11. Rent to be paid in future years under the current rental agreement:

Fiscal Year EndingAnnual Rent
12. /2013 \$
13. /2014 \$
14. /2015 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

**Lebanon Care Center
0049064**

Period Beginning **1/1/2012**
Period End **12/31/2012**

Schedule 14A

XII. Rental Costs
B. Equipment
16. Description of rental amount for movable equipment

Medical Equipment	\$	4,050
Dishwasher		831
Laundry Equipment		-
Copier		4,035
Home Office Allocation		490
		<u>9,406</u>

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?

☐ YES
☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
COMMUNITY COLLEGE☐
HOURS PER CNA_____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☐
IN OTHER FACILITY☐
HOURS PER CNA_____

B. EXPENSES

C. CONTRACTUAL INCOME

ALLOCATION OF COSTS (d)

In the box below record the amount of income your facility received training CNAs from other facilities.

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)										
		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10A(3)	hrs	\$	6,206	\$ 93,093	\$	6,206	\$ 93,093	1
2	Licensed Speech and Language Development Therapist	10A(3)	hrs		2,185	32,779		2,185	32,779	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A(3)	hrs		6,565	98,469		6,565	98,469	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39(2)	# of prescrpts				46,637		46,637	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify): Respiratory Therapy	10A(3)			7	110		7	110	13
14	TOTAL			\$	14,963	\$ 224,451	\$ 46,637	14,963	\$ 271,088	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (261,659)	\$ (261,659)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>202,500</u>)	824,666	824,666	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,722	27,722	6
7	Other Prepaid Expenses	9,431	9,431	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 600,160	\$ 600,160	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	115,000	100,000	13
14	Buildings, at Historical Cost	1,425,000	1,432,268	14
15	Leasehold Improvements, at Historical Cost	174,655	190,334	15
16	Equipment, at Historical Cost	299,862	299,863	16
17	Accumulated Depreciation (book methods)	(567,950)	(505,867)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>A/R Prior Owner</u>	6,897	6,897	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,453,464	\$ 1,523,495	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,053,624	\$ 2,123,655	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 528,998	\$ 528,998	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	58,846	58,846	30
31	Accrued Taxes Payable (excluding real estate taxes)	24,491	24,491	31
32	Accrued Real Estate Taxes(Sch.IX-B)	62,844	62,844	32
33	Accrued Interest Payable	11,282	11,282	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Payroll Withholdings</u>	35,061	35,061	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 721,522	\$ 721,522	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,814,674	1,814,674	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,814,674	\$ 1,814,674	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,536,196	\$ 2,536,196	46
47	TOTAL EQUITY(page 18, line 24)	\$ (482,572)	\$ (412,541)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,053,624	\$ 2,123,655	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 308,373	1
2	Restatements (describe):		2
3	Rounding		3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 308,373	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(790,945)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (790,945)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (482,572)	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Lebanon Care Center# 0050609Report Period Beginning: 1/1/2012Ending: 12/31/2012

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1		2
I. Revenue	Amount		
A. Inpatient Care			
1 Gross Revenue -- All Levels of Care	\$ 1,868,557	1	
2 Discounts and Allowances for all Levels	(128,271)	2	
3 SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,740,286	3	
B. Ancillary Revenue			
4 Day Care		4	
5 Other Care for Outpatients		5	
6 Therapy	364,694	6	
7 Oxygen	1,051	7	
8 SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 365,745	8	
C. Other Operating Revenue			
9 Payments for Education		9	
10 Other Government Grants		10	
11 CNA Training Reimbursements		11	
12 Gift and Coffee Shop		12	
13 Barber and Beauty Care		13	
14 Non-Patient Meals	3,449	14	
15 Telephone, Television and Radio		15	
16 Rental of Facility Space		16	
17 Sale of Drugs	64,334	17	
18 Sale of Supplies to Non-Patients		18	
19 Laboratory		19	
20 Radiology and X-Ray	3,845	20	
21 Other Medical Services	1,540	21	
22 Laundry		22	
23 SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 73,168	23	
D. Non-Operating Revenue			
24 Contributions		24	
25 Interest and Other Investment Income***	1,458	25	
26 SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 1,458	26	
E. Other Revenue (specify):****			
27 Settlement Income (Insurance, Legal, Etc.)		27	
28 Miscellaneous Revenue	1,002	28	
28a Transportation Revenue	2,781	28a	
29 SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 3,783	29	
30 TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,184,440	30	

	1		2
II. Expenses	Amount		
A. Operating Expenses			
31 General Services	536,932	31	
32 Health Care	1,158,525	32	
33 General Administration	531,188	33	
B. Capital Expense			
34 Ownership	325,691	34	
C. Ancillary Expense			
35 Special Cost Centers	217,974	35	
36 Provider Participation Fee	205,075	36	
D. Other Expenses (specify):			
37		37	
38		38	
39		39	
40 TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,975,385	40	
41 Income before Income Taxes (line 30 minus line 40)**	(790,945)	41	
42 Income Taxes		42	
43 NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (790,945)	43	

III. Net Inpatient Revenue detailed by Payer Source			
44 Medicaid - Net Inpatient Revenue	\$ 1,026,217	44	
45 Private Pay - Net Inpatient Revenue	425,340	45	
46 Medicare - Net Inpatient Revenue	292,496	46	
47 Other-(specify) <u>Charity Therapy Allowance</u>	(2,978)	47	
48 Other-(specify) <u>Insurance Contractual Allowance Revenue</u>	(789)	48	
49 TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$ 1,740,286	49	

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income

Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,869	1,869	\$ 59,887	\$ 32.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,803	2,847	75,641	26.57	3
4	Licensed Practical Nurses	14,778	15,060	308,753	20.50	4
5	CNAs & Orderlies	30,447	30,581	315,476	10.32	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,855	1,855	22,762	12.27	9
10	Activity Assistants					10
11	Social Service Workers	2,037	2,037	35,070	17.22	11
12	Dietician					12
13	Food Service Supervisor	2,061	2,114	26,413	12.49	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,178	11,248	100,397	8.93	15
16	Dishwashers					16
17	Maintenance Workers	1,723	1,787	26,803	15.00	17
18	Housekeepers	12,535	12,668	116,122	9.17	18
19	Laundry	656	741	6,889	9.30	19
20	Administrator	2,080	2,080	52,147	25.07	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,056	2,080	26,224	12.61	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care: <u>Care Plan Coord</u>	1,915	1,988	45,558	22.92	32
33	Other(specify) <u>Transportation</u>	289	289	2,894	10.01	33
34	TOTAL (lines 1 - 33)	88,282	89,244	\$ 1,221,036 *	\$ 13.68	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	13,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,054	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 16,854		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	12	\$ 863	L10, C3	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	12	\$ 863		53

Template

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 20A

XVIII. Staffing and Salary Costs

	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
Care Plan Coordinator	-	-		#DIV/0!
Restorative Aide				#DIV/0!
Certified Medical Technician				#DIV/0!
Alzheimer's Coordinator				#DIV/0!
Restorative Nurse				#DIV/0!
Transportation	-	-	-	#DIV/0!
Marketing				#DIV/0!
TOTAL				

XIX. SUPPORT SCHEDULES

A. Administrative Salaries	D. Employee Benefits and Payroll Taxes	F. Dues, Fees, Subscriptions and Promotions
NameFunction%AmountDeborah CutrightAdministrator0\$29,792Beverly GoodmanAdministrator016,147Martin OlsonAdministrator06,208TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)\$52,147	DescriptionAmountWorkers' Compensation Insurance\$35,043Unemployment Compensation Insurance39,325FICA Taxes89,828Employee Health Insurance6,829Employee MealsIllinois Municipal Retirement Fund (IMRF)*Employee Relations750Home Office Allocation515TOTAL (agree to Schedule V, line 22, col.8)\$172,290	DescriptionAmountIDPH License Fee\$Advertising: Employee Recruitment63Health Care Worker Background Check (Indicate # of checks performed)Patient Background Checks56568Miscellaneous Licenses & Permits658Miscellaneous Dues & Subscriptions(50)(50)Home Office Allocation332Less: Public Relations ExpenseNon-allowable advertisingYellow page advertisingTOTAL (agree to Sch. V, line 20, col. 8)\$1,571
B. Administrative - OtherDescriptionAmountManagement Fees-Ser Page 6, Eliminated on P 3, C 7\$268,600TOTAL (agree to Schedule V, line 17, col. 3) \$268,600 (Attach a copy of any management service agreement)	E. Schedule of Non-Cash Compensation Paid to Owners or EmployeesDescriptionLine #AmountN/TOTAL\$	G. Schedule of Travel and Seminar**DescriptionAmountOut-of-State Travel\$In-State TravelSeminar ExpenseHome Office Allocation5Entertainment Expense(TOTAL (agree to Sch. V, line 24, col. 8))\$5
C. Professional ServicesVendor/PayeeTypeAmountE-Health Data SolutionsComputer Services\$1,460AT&TComputer Services320Sorling, Northrup, HannaLegal Services9,555TOTAL (agree to Schedule V, line 19, column 3) \$11,335 (If total legal fees exceed \$5,000, attach copy of invoices.)		

*** Attach copy of IMRF notifications**

****See instructions.**

Lebanon Care Center
0049064
Period Beginning 1/1/2012
Period End 12/31/2012

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Vendor/Payee	Type	Amount
Total (agree to Schedule V, line 19, column 3)		11,335
Home Office Allocation		
Sorling Northrup	Legal	49
Ginoli & Company	Accountants	1,702
Miscellaneous	Computer Services	113
Nebo Systems	Computer Services	1
Advanced Answers on Demand	Computer Services	2361
Access 2 Go	Computer Services	99
Stratus Networks	Computer Services	98
Kemper Technology	Computer Services	161
CCH	Computer Services	8
Medifax	Computer Services	19
Vision Share/Ability Network	Computer Services	180
Barracuda	Computer Services	6
CIAN	Computer Services	49
Comcast	Computer Services	15
Postini	Computer Services	153
Optimizer Systems	Other Prof Fees	24
Marotta Gund Budd & Dzera	Other Prof Fees	10934
David Budde	Other Prof Fees	9
Courtney Bourban	Other Prof Fees	134
All Scripts	Other Prof Fees	412
Heritage Enterprises	Other Prof Fees	10
Miscellaneous Vendors	Other Prof Fees	3
Duane Morris	Legal	136
Peoria County Recorder	Legal	3
E-Health Data Solutions	Computer Services	36

Ability Network	Computer Services	309
Market Feasibility Advisors	Other Prof Fees	905
Total (agree to Schedule V, line 19, column 8)		<u>29,264</u>

Lebanon Care Center
0049064

Period Beginning 1/1/2011
Period End 12/31/2011

Schedule 21B

XIX. SUPPORT SCHEDULE
Legal Fees

Facility

Vendor/Payee	Invoice Total	Allocation %	Total
Sorling, Northrup, Hanna, Cullen & Cochran	525.00	100%	525
Sorling, Northrup, Hanna, Cullen & Cochran	2,205.00	100%	2,205
Sorling, Northrup, Hanna, Cullen & Cochran	577.50	100%	578
Sorling, Northrup, Hanna, Cullen & Cochran	892.50	100%	893
Sorling, Northrup, Hanna, Cullen & Cochran	1,932.00	100%	1,932
Sorling, Northrup, Hanna, Cullen & Cochran	367.50	100%	368
Sorling, Northrup, Hanna, Cullen & Cochran	220.50	100%	221
Sorling, Northrup, Hanna, Cullen & Cochran	42.00	100%	42
Sorling, Northrup, Hanna, Cullen & Cochran	1,407.00	100%	1,407
Sorling, Northrup, Hanna, Cullen & Cochran	315.00	100%	315
Sorling, Northrup, Hanna, Cullen & Cochran	462.00	100%	462
Sorling, Northrup, Hanna, Cullen & Cochran	462.00	100%	462
Sorling, Northrup, Hanna, Cullen & Cochran	42.00	100%	42
Sorling, Northrup, Hanna, Cullen & Cochran	105.00	100%	105
		100%	-
Home Office Allocation			
Sorling Northrup	5,053.00	0.97%	49
Duane Morris	1,811.00	7.50%	136
Peoria County Recorder	42.00	7.50%	3
			-
			-
Total Legal Fees			9,743

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs.
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 9,438 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 205,075
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,449
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 2,781
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.